

VA Facility Name:

INSTRUCTIONS: The CWT Admission Survey should be completed as close to the day of admission as possible. The information in Part I should be obtained via a face-to-face interview with the veteran, and the CLINICIAN, not the veteran, should enter the information into the computer. Part II should be completed by a clinician using all information sources necessary to answer the survey completely, including the medical record.

No questions should be left blank - you must enter a response to every question on the survey.

PLEASE ENTER THIS DATA INTO THE ELECTRONIC FORM.

DO NOT SEND THIS FORM TO NEPEC.

TO ADD A NEW PATIENT INTO THE SYSTEM COMPLETE THE FOLLOWING:

Veteran's Last Name:

Veteran's First Name:

Social Security Number:

Date of Birth: mm-dd-yyyy

Gender: Male ☐ Female ☐

Ethnicity (check only one):

- ☐ Hispanic white
- ☐ Hispanic black
- ☐ American Indian/Alaskan
- ☐ Black, not Hispanic
- ☐ Asian
- ☐ White
- ☐ Other

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Marital Status (check only one):

1. ☐ Married
2. ☐ Remarried
3. ☐ Widowed
4. ☐ Separated
5. ☐ Divorced
6. ☐ Never married

Highest level of education: (e.g., GED =12; 1 yr college = 13; enter 6-20 or DK for Don't Know)

COMPENSATED WORK THERAPY: ADMISSION FORM
PART I. INTERVIEW – TO BE ADMINISTERED TO THE VETERAN BY THE CLINICIAN

Three or Five Digit VA Station Code: Facility Suffix (if applicable):

1. Date form completed: [R] mm-dd-yyyy
2. Name of staff completing form (Last name, First Initial): [R]
3. Email address of staff completing form and doing quarterly updates (ex: va.employee@med.va.gov): [R]
4. Date admitted to CWT: [R] mm-dd-yyyy
5. Have you ever worked in CWT before this admission? Yes ☐ No ☐ Don't Know ☐
6. How many months of training or technical education have you completed (exclude training in the military)?
[R] (Enter 00 if none or DK for Don't Know)
7. What has been your usual employment pattern during the past three years? (check only one):

Full time competitive employment (>=35 hours/wk).....	<input type="checkbox"/>	Service/Volunteer	<input type="checkbox"/>
Part time competitive employment (<35 hours/wk)	<input type="checkbox"/>	Retired/Disabled	<input type="checkbox"/>
Irregular part time (day jobs)	<input type="checkbox"/>	Unemployed.....	<input type="checkbox"/>
Student/training program	<input type="checkbox"/>	Other.....	<input type="checkbox"/>

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8. In the last 30 days, how many days did you work for pay? (exclude CWT and IT) Enter 0-30

9. In the last 30 days, how much did you receive from employment? (exclude CWT and IT) \$.00 [R]
(enter 00 if none, DK for Don't Know)

10. Do you currently receive any of the following kinds of financial support?

- | | | | |
|--|------------------------------|-----------------------------|-------------------------------------|
| a. Service Connected Psychiatry (include 0%) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| b. Service Connected Other (include 0%) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| c. NSC Pension | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| d. SSDI (Social Security Disability Insurance) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| e. SSI (Supplemental Security Income) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| f. Social Security Retirement | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| g. Other disability (e.g. workmen's compensation) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| h. Other public support (e.g. food stamps, general relief) ... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| i. Other pension/retirement (e.g. military pension) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |

11. In the past 30 days, how much money did you receive from these sources combined? \$.00[R]
(Code 0000 if the veteran does not receive any of the above support or enter DK for Don't Know)

12. Period of Service (select period in which the veteran saw combat; if none, select the longest period served) Please check only one:

- a. ☐ Pre-WWII (11/18 – 11/41)
- b. ☐ WWII (12/41 – 12/46)
- c. ☐ Pre-Korean War (1/47 – 6/50)
- d. ☐ Korean war (7/50 – 1/55)
- e. ☐ Between Korean and Vietnam Eras (2/55 – 7/64)
- f. ☐ Vietnam Era (8/64 – 4/75)
- g. ☐ Post Vietnam (5/75 – 7/90)
- h. ☐ Persian Gulf (8/90 -)

13. Did you serve in the theatre of operations for any of the following military conflicts?

- a. World War II: Yes ☐ No ☐
- b. Korean War..... Yes ☐ No ☐
- c. Vietnam War:Yes ☐ No ☐
- d. Persian Gulf War (Operation Desert Storm):Yes ☐ No ☐
- e. Afghanistan (Operation Enduring Freedom)..... Yes ☐ No ☐
- f. Iraq (Operation Iraqi Freedom):Yes ☐ No ☐
- g. Other peace-keeping operations or military interventions
(such as Lebanon, Panama, Somalia Bosnia, Kosovo): Yes ☐ No ☐

14. Did you ever receive hostile or friendly fire in a combat zone? Yes ☐ No ☐

15. Where did you usually sleep during the month before you were admitted to the CWT program? (check only one):

- a. ☐ Own apartment, room, or house (including boarding homes, SROs, etc)
- b. ☐ Apartment, room, or house of a friend or family member
- c. ☐ Halfway house/transitional living program
- d. ☐ Institution (e.g., hospital, nursing home, domiciliary)
- e. ☐ No available residence other than homeless shelters, outdoors, etc
- f. ☐ Don't know

16. On the last date you were living in the community (e.g. not in a hospital or health care facility) were you homeless? (Homeless is defined as lacking a fixed, regular, and adequate night-time residence)

..... Yes ☐ No ☐

a. If yes, how long was that episode of homelessness?

NOTE: length of time homeless is determined by calculating the number of months or years since the veteran has had a fixed, regular and adequate night-time residence, and then subtracting the number of months or years spent in any institution (including hospitals, halfway houses, correctional facilities, etc.)

☐ N/A

☐ At least 1 year but less than 2 years

☐ Less than 1 month

☐ Two years or more

☐ At least 1 month but less than 6 months

☐ Unknown

☐ At least 6 months but less than 1 year

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17. In the last 30 days, have you at least once drunk alcohol to the point of intoxication?

Yes ☐ No ☐ Don't Know ☐

18. In the last 30 days, have you used any drugs that haven't been prescribed by a doctor?

Yes ☐ No ☐ Don't Know ☐

19. Have you ever been hospitalized for:

- a. Treatment of alcoholism: Yes ☐ No ☐
- b. Treatment of a drug problem: Yes ☐ No ☐
- c. A psychiatric or emotional problem (include PTSD): Yes ☐ No ☐

20. Which of the following health problems do you currently have?

- a. Medical problem: Yes ☐ No ☐
- b. Problem with alcohol: Yes ☐ No ☐
- c. Problem with drugs: Yes ☐ No ☐
- d. Psychiatric or emotional problem: Yes ☐ No ☐

21. Have you ever lost a job because of alcohol and/or drug problems? Yes ☐ No ☐

22. Have you ever been arrested? (check only one):

- ☐ No
- ☐ Yes, once
- ☐ Yes, 2 to 5 times
- ☐ Yes, 6 to 10 times
- ☐ Yes, more than 10 times

23. Have you ever been incarcerated in a correctional facility during your lifetime? (check only one):

- ☐ No
- ☐ Yes, less than 2 weeks
- ☐ Yes, 2 weeks or more

24. There are several kinds of jobs available through the CWT program. Although you may start out working in a transitional work experience, **is working in a competitive job your ultimate employment goal?** (By competitive, I mean a paid job in the community where you work directly for the employer, not the CWT program). Please check only one.

- ☐ Yes (would like a competitive job)
- ☐ No (would not like a competitive job)
- ☐ Don't Know

PART II. CLINICIAN'S OBSERVATIONS AND IMPRESSIONS

25. How was the contact with the CWT program initiated? Please check only one.

- a. Referral from a VA inpatient unit (other than SCI or Polytrauma)..... ☐
- b. Referral from a VA outpatient unit (other than SCI or Polytrauma)..... ☐
- c. Referral from a VA domiciliary or residential unit ☐
- d. Referral from a non-VA health care provider/agency ☐
- e. Self-referred ☐
- f. Referral from a Vet Center ☐
- g. Referral from a SCI or Polytrauma Unit (inpatient OR outpatient)..... ☐

26. Is the veteran currently in a VA residential program or inpatient unit?Yes ☐ No ☐

27. Please indicate below the veteran's DSM-IV diagnosis as determined by professionals in this program or from the medical record:

- | | | | |
|---|------------------------------|-----------------------------|-------------------------------------|
| a. PTSD: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| b. Anxiety disorder (other than PTSD): | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| c. Affective disorder/depression (other than bipolar disorder): ... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| d. Bipolar disorder: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| e. Schizophrenia: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| f. Psychosis: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| g. Adjustment disorder: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |
| h. Alcohol abuse or dependence: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Don't Know <input type="checkbox"/> |

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- i. Drug abuse or dependence:Yes ☐ No ☐ Don't Know ☐
- j. Personality disorder: Yes ☐ No ☐ Don't Know ☐
- k. Other psychiatric diagnosis: Yes ☐ No ☐ Don't Know ☐

Specify other:

28. Please indicate below any disabling medical conditions that apply to this veteran as determined by professionals in this program or from the medical record.

- a. Head injury:Yes ☐ No ☐ Don't Know ☐
- b. Cerebro-vascular accident (e.g. stroke): Yes ☐ No ☐ Don't Know ☐
- c. Spinal cord injury (paraplegia/quadruplegia): Yes ☐ No ☐ Don't Know ☐
- d. Arthritis:Yes ☐ No ☐ Don't Know ☐
- e. Multiple Sclerosis: Yes ☐ No ☐ Don't Know ☐
- f. Liver disease (e.g. cirrhosis): Yes ☐ No ☐ Don't Know ☐
- g. Pulmonary disease (e.g. COPD): Yes ☐ No ☐ Don't Know ☐
- h. Hypertension:Yes ☐ No ☐ Don't Know ☐
- i. Coronary Heart Disease: Yes ☐ No ☐ Don't Know ☐
- j. Dementia:Yes ☐ No ☐ Don't Know ☐
- k. Orthopedic problems (e.g. back injury): Yes ☐ No ☐ Don't Know ☐
- l. Diabetes: Yes ☐ No ☐ Don't Know ☐
- m. Other medical problems: Yes ☐ No ☐ Don't Know ☐

29. GAF SCORE: Please rate this veteran's level of functioning over the past 30 days..... [R]
 where 01 is complete absence of functioning and 99 is exceptional functioning;
 Enter "NQ" if the employment specialist is not qualified to make a rating, or enter
 "NI" if there is not enough information to make assessment.

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